

**WEST VIRGINIA MONITORING WELL DRILLERS'  
MAILING ADDRESS VERIFICATION FORM**

**DATE:** \_\_\_\_\_

**FULL NAME:** \_\_\_\_\_  
Last First Middle

**BUSINESS NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**BUSINESS TELEPHONE:** \_\_\_\_\_

**BUSINESS FAX:** \_\_\_\_\_

**SOCIAL SECURITY #** \_\_\_\_\_

**RESIDENCE ADDRESS:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**RESIDENCE TELEPHONE:** \_\_\_\_\_

**APPLICANT VERIFIED BY:** \_\_\_\_\_

\_\_\_\_\_

**EW-122**

**West Virginia Department of Environmental Protection (WVDEP) and West Virginia Bureau for Public Health (WVBPH)**

**Certified Monitoring Well Driller (CMWD) Application**

(Please print or type your answers to applicable questions)

**Please read before completing this application:** This application complies with Title 47 Series 59, *Monitoring Well Rules*, effective June 1, 1994. Section 7.1 of the above rule states: *“The secretary may suspend, revoke or deny certification if the information on the application form is incomplete, inaccurate, false or misleading, or if provisions of this rule or any other rule pertaining to monitoring wells are willfully or negligently violated.”*

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**Section One:**  
 Applicant Name: \_\_\_\_\_ Home Phone Number: \_\_\_\_\_  
 Applicant Address: \_\_\_\_\_ Email address: \_\_\_\_\_  
 \_\_\_\_\_ Zip Code: \_\_\_\_\_

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**Section Two:**  
 Business Name: \_\_\_\_\_ Business Phone Number: \_\_\_\_\_  
 Business Address: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
 \_\_\_\_\_ Zip Code: \_\_\_\_\_

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**Section Three:**  
 Applicant Education Level:    \_\_\_ High School or GED,                    \_\_\_ 1-2 Years of College or Vocational School  
 (Please Check One)                    \_\_\_ 3-4 Years of College,                    \_\_\_ More than 4 years of college,  
    \_\_\_ Other (describe) \_\_\_\_\_.

**Section Four:** Please provide reference information for three people who can verify your drilling experience, either certified in another state, province or territory, or from drilling under a CMWD for at least two (2) years prior to the date of this application.

<u>Individual or Business Name:</u>	<u>Mailing Address with Zip Code:</u>	<u>Contact Numbers:</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

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**Section Five:** Please sign and date this application in the spaces below.  
 CMWD Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**Section Six:** Have your supervising CMWD sign and date this application and place their certification # and state, province or territory where certified, in the space provided:  
 Supervising CMWD Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Certification #: \_\_\_\_\_ State Certified: \_\_\_\_\_

**Section Seven:** If you are applying for CMWD based on your certification in another state, province or territory, you must provide a copy of that current certification with this application.

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Date Application received: \_\_\_\_\_ Date of Review: \_\_\_\_\_  
 Name of Reviewer: \_\_\_\_\_ Approved or \_\_\_\_\_ Disapproved